

consistent with results from unselected observational studies of mortality in Parkinson's disease.¹⁰

So should clinicians use MAOBIs for newly diagnosed patients? These drugs clearly provide symptomatic benefit and probably entail no risk of increased mortality if they are used as monotherapy and in younger and otherwise healthy patients. However, as Ives et al conclude, data on comparative efficacy with other first line drugs, particularly dopamine agonists, is lacking.² In general, drugs used to treat Parkinson's disease show a seesaw effect—those that are better at improving motor disability tend to have greater risks of complications and vice versa. The best choice of treatment for an individual patient will be determined by the patient's own preferences in balancing motor benefits against the onset and degree of motor complications.

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it had published its initial report (reference 4) and subsequently published reference 7.

- 1 Lees AJ, on behalf of the Parkinson's Disease Research Group of the United Kingdom. Comparison of therapeutic effects and mortality data of levodopa and levodopa combined with selegiline in patients with early, mild Parkinson's disease. *BMJ* 1995;311:1602-7.
- 2 Ives NJ, Stowe RL, Marro J, Counsell C, Macleod A, Clarke CE, et al. Monamine oxidase type B inhibitors in early Parkinson's disease: meta-analysis of 17 randomised trials involving 3525 patients. *BMJ* 2004; 329:593-6.
- 3 Anonymous. MAO-B inhibitors for the treatment of Parkinson's disease. *Movement Disord* 2002;17(suppl 4):s38-s44.
- 4 Rascol O, Goetz C, Koller W, Poewe W, Sampaio C. Treatment interventions for Parkinson's disease: an evidence based assessment. *Lancet* 2002;359:1589-98.
- 5 Teo KK, Yusuf S, Pfeffer M, Torp-Pedersen C, Kober L, Hall A, et al. Effects of long-term treatment with angiotensin-converting-enzyme inhibitors in the presence or absence of aspirin: a systematic review. *Lancet* 2002;360:1037-43.
- 6 Egger M, Davey Smith G, Schneider M, Minder C. Bias in meta-analysis detected by a simple, graphical test. *BMJ* 1997;315:629-34.
- 7 Ben-Shlomo Y, Churchyard A, Head J, Hurwitz B, Overstall P, Ockelford J, et al. Investigation by Parkinson's disease research group of United Kingdom into excess mortality seen with combined levodopa and selegiline treatment in patients with early, mild Parkinson's disease: further results of randomised trial and confidential inquiry. *BMJ* 1998; 316:1191-6.
- 8 Parkinson Study Group. Mortality in DATATOP: a multicenter trial in early Parkinson's disease. *Ann Neurol* 1998;43:318-25.
- 9 Lees AJ, Katzenschlager R, Head J, Ben Shlomo Y. Ten-year follow-up of three different initial treatments in de-novo Parkinson's disease: a randomized trial. *Neurology* 2001;57:1687-94.
- 10 Ben-Shlomo Y, Marmot MG. Survival and cause of death in a cohort of patients with parkinsonism: possible clues to aetiology. *J Neurol Neurosurg Psychiatry* 1995;58:293-9.

The patient's journey: travelling through life with a chronic illness

A new BMJ series to deepen doctors' understanding

For many years we have been keen to bring patients' voices into the *BMJ* by publishing personal views and commentaries by patients. Now we are starting a new intermittent series of longer articles describing patients' experiences of living with chronic disease. The first of these articles is published today,¹ and we hope that readers will send us more along the same lines.

This journey describes the challenges of living with Parkinson's disease, and is written by Mary Baker and Lizzie Graham of the European Parkinson's Disease Association. The article started life as a speech by Mary Baker. It has no formal references and has a rousing and almost mythical style, following a long tradition of patients' tales.² Subsequent articles may conform to the same style and structure but do not have to (see box).

Journey articles should encompass how it feels to face a difficult diagnosis and what that does to relationships and quality of life. Inevitably and importantly, they will underline the need to treat patients, rather than diseases, and to understand the impact such journeys may also have on patients' carers and families. Above all, these articles should tell doctors what really matters to patients and what help they need to make the most of their lives. As Aldous Huxley said, "Experience is not what happens to a man; it is what a man does with what happens to him."³ Giving patients time and space to talk about what happens to them might help to improve their experiences of illness.

The variety of lessons to be learnt from such journeys is almost as great and diverse as the range of long term experiences they may describe. Patients and carers must be actively and directly involved in the preparation of the articles. We do not believe that doctors and journalists acting as proxies for patients will be able to tell sufficiently convincing stories.

It would be interesting, however, to see a journey described both by a patient or carer and by clinicians who have helped that patient, perhaps in parallel

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Issues to cover in *BMJ* patient's journey articles

The map: an outline of the natural course of the disease
The good and bad news: What's wrong with me? What is going to happen to me? How is it going to end?
Travelling alone: Losing independence and dealing with changing relationships and social roles
Companions on the journey: Friends and family, professionals, support organisations
Ways of coping
What I need along the way: Information, help, and treatment
Losing the path: Other problems that may arise over time
Travellers' tales: One or more brief stories and quotes from real patients—highlighted by one 300-word personal account
Journey's end

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articles and without comparing notes. And it would be interesting, too, to see two or more comparable journeys described by the patients who made them, or their carers, for that might show the individuality and uniqueness of each person facing the same challenge.

The *BMJ* is beginning this new series of articles for two main reasons. Firstly, this is a response to the growing recognition, certainly within the United Kingdom, that health services that have tended to focus largely on acute or life threatening illnesses must do more to improve the diagnosis, treatment, and management of chronic diseases. This is an imperative driven partly by an ageing population and a consequent increase in the incidence of chronic illness⁴ but also by the realisation that the quality of people's lives may be at least as important to them as the lengths of their lives.

Secondly, we hope that this new series will develop the *BMJ*'s strategy to include patients in its work. Last year, with Mary Baker's assistance, the then editor, Richard Smith, established the *BMJ*'s advisory group for patients. This group comprises more than a dozen people representing a wide variety of patients' organisations, which provide support and information about many different diseases.

Meeting only occasionally, the group is an essentially virtual forum whose members are actively encouraged to comment on the *BMJ* and on issues affecting patients, and to become involved in the journal's work. Some of this work leads to publication, and some of it is internal and editorial.⁵ For instance several

of the group's members have joined the weekly rota to critique each issue of the *BMJ* after publication.

This series of patient journeys will, we hope, further promote the importance of patients' voices and of narrative based medicine. We believe that doctors should be able to draw on all aspects of evidence—case based experience, the patient's individual and cultural perspectives, and the results of rigorous clinical research trials and observational studies—to reach an integrated clinical judgment.⁶ We will be pleased to hear your views on this first journey article and receive others co-written by any combination of patients, patient advocates, carers, and clinicians.

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- 1 Baker MG, Graham L. The journey: Parkinson's disease. *BMJ* 2004; 329:611-4.
- 2 Aronson JK. Autopathography: the patient's tale. *BMJ* 2000;321:1599-602.
- 3 Huxley A. Introduction. *Texts and pretexts: an anthology of commentaries*. London: Chatto and Windus, 1932.
- 4 Khaw KT. How many, how old, how soon? *BMJ* 1999;319:1350-2.
- 5 Shaw J, Baker M. "Expert patient"—dream or nightmare? *BMJ* 2004; 328:723-4.
- 6 Greenhalgh T. Narrative based medicine: Narrative based medicine in an evidence based world. *BMJ* 1999;318:323-5.

Ethnic profile of the doctors in the United Kingdom

A diverse group of doctors would appreciate the concerns of the population better

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The population of doctors working in the United Kingdom differs notably in ethnic profile from the wider population. Of the almost 81 000 doctors employed by trusts in England in 2003, 63% were white, 23% Asian, 4% black, 1% of mixed race, and 7% from other ethnic groups (2% unrecorded).¹ White people make up 92% of the population of the United Kingdom.²

Two reasons exist for this difference. Firstly, the United Kingdom is a net importer of doctors, recruiting an increasing number trained in other countries, many of non-white ethnicity. Secondly, more British ethnic minority students are entering medicine. In this issue Goldacre et al show that the percentage of non-white doctors among UK graduates has increased substantially, from about 2% in 1974 to almost 30% by 2005 (p 597).³ The ethnic profile of students entering medical school is different from that of the university age population, with white men under-represented and Asian men and women over-represented. White men now comprise little more than a quarter of all medical students in the United Kingdom but 44% of the university age population. A recent study calculates a 10-fold difference in standardised admission ratios by ethnicity.⁴

A difference between the population of doctors and the wider population has been clearly established with respect to ethnic profile. This is not the only

dimension for which there will be differences, especially when specialties are looked at individually. There will also be a lack of mirroring across a range of other dimensions including sex, socioeconomic background, disability, religion, and sexual orientation. Does this matter, and if so, how?

One argument could be that the demographic profile of the medical workforce has never reflected that of the population served and is irrelevant. At an individual level this is a reasonable argument—patients are likely to be concerned more with the competencies of their doctors than their background. However, at the level of the entire healthcare system it is a concern if medical professionals who have great influence over policy and delivery of health care do not broadly reflect diversity in the wider population. This is because a diverse group of doctors should appreciate the concerns and priorities of the whole population better and because differences may indicate discrimination.

Does the difference in ethnic profile reflect discrimination? Sadly, evidence shows that racism continues in medicine and is experienced by patients and doctors.^{5 6} In terms of direct discrimination, students from ethnic minorities are discriminated against at entry to medical school.⁷ Students from lower socioeconomic backgrounds are massively under-represented at medical school, and this is not explained by lower academic

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